Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: HARRIS METHODIST FORT WORTH 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-07-5659-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: LIBERTY INSURANCE CORP Box #: 28	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit that the carrier, Liberty Mutual did not pay the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. The patient was seen for a fracture of the ankle. With a diagnosis code of 824.9, this claim is considered a 'trauma' admit, for this reason it can be exempt from the perdiem rates. The carrier paid for the perdiem and implants. We are not with the understanding that TWCC will find reimbursement on trauma claims paid at *less than* the applicable fee schedule to be acceptable. According to information we have received from TWCC regarding a medical billing database for services in 2004, trauma claims received and average payment that was 48.2% of charges. Because this information was acquired from TWCC from a Medical Dispute filed, we are considering this to be a 'fair and reasonable' calculation for trauma reimbursement. With that said this claim should have been paid at $12,699.04."

Amount in Dispute: $6,760.04

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**The provider was reimbursed per the TX FS at the inpatient surgical per diem of $1118.00 X 3 days = $3354.00 plus implants at cost plus 10% per facilities invoices ($2350.00 + 10% = $2585.00). Total payment made per TX FS: $5939.00. No PPO discount was applied."** "Liberty Mutual does not believe that Harris Methodist Fort Worth Hospital is due any further reimbursement…"

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
9/15/2006 through 9/18/2006	W10, Z585, W1, Z710, Z695, X598, Z951	Inpatient Trauma Surgery Admission	$6,760.04	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on April 30, 2007.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

- W10, Z585-The charge for this procedure exceeds fair and reasonable.
- W1, Z710-The charge for this procedure exceeds the fee schedule allowance.
- Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- Z951-We are unable to recommend an additional allowance since this claim was paid in accordance with the

state's fee schedule guidelines, First Health Bill review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health.

2. The Respondent raised the issue of a PPO contract, EOB denial reason code Z951; however, a review of the submitted EOBs does not support a PPO reduction was taken. Neither party submitted a copy of a contractual agreement to support this EOB denial; therefore, the disputed services will be reviewed in accordance with §134.401.
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.9. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all medical bill(s)… as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(A).
7. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
8. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement states that "We have found in this audit that the carrier, Liberty Mutual did not pay the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. The patient was seen for a fracture of the ankle. With a diagnosis code of 824.9, this claim is considered a 'trauma' admit, for this reason it can be exempt from the perdiem rates. The carrier paid for the perdiem and implants. We are not with the understanding that TWCC will find reimbursement on trauma claims paid at *less than* the applicable fee schedule to be acceptable. According to information we have received from TWCC regarding a medical billing database for services in 2004, trauma claims received and average payment that was 48.2% of charges. Because this information was acquired from TWCC from a Medical Dispute filed, we are considering this to be a 'fair and reasonable' calculation for trauma reimbursement. With that said this claim should have been paid at $12,699.04."
   - The requestor did not provide a copy of or citation to any Division Medical Dispute decision.
   - The requestor did not provide documentation of information from TWCC regarding a medical billing database for services in 2004, supporting that trauma claims received an average payment that was 48.2% of charges.
   - The requestor does not discuss or explain how payment of 48.2% of charges would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed

charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

- The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	**10/6/2010** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.